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ABSTRACT

After years of neglect, rural community mental health is becoming a legitimate area of specialization. Although the number of problems readily visible in rural mental health may appear to be inordinate, probabilities are that the difficulties found in rural locales are quantitatively no different than those found in non-rural areas. The differences may be purely qualitative. This comprehensive literature review provides a summary of the problems faced by mental health professionals in the establishment and delivery of mental health services in rural areas. Critical issues and problem areas discussed include models of community mental health care; some characteristics of rural areas; values of rural citizens; issues to be faced by the mental health center and its personnel in their entry into the rural human service delivery system; and barriers to service delivery in rural areas, which include geographical, financial, educational, and psycho-social factors. The issues of confidentiality, professional and personal problems of the rural mental health professional are addressed. Four areas of importance to rural mental health given special attention are program evaluation, univeristy activities, national organizational efforts, and the flux of rural America. A bibliography of 67 references is included. (Author/NEC)

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Problems and Issues in Rural Community Mental Health: A Review

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Abstract

Rural community mental health is becoming a legitimate area of specialization. A comprehensive review of the literature is presented. Critical issues and problem areas discussed include models of community mental health care; some characteristics of rural areas; issues to be faced by the mental health center and its personnel in their entry into the rural human service delivery system; and barriers to service delivery in rural areas, which include geographical, financial, educational, and psychosocial factors. The issues of confidentiality, professional and personal problems of the rural mental health professional, and selected special topics are addressed.

PROBLEMS AND ISSUES IN RURAL COMMUNITY MENTAL HEALTH: A REVIEW

Historically, rural areas have been the least advanced in general community health services (HEW, 1973a). In particular, mental health care has been the most neglected aspect of health services in rural areas (Barten & Bellack, 1972; Eisdorfer, Altrocchi, & Young, 1968; Naftulin, Donnelly, & O'Halloran, 1974). Although mental health services in rural areas are beginning to receive increased attention (Clayton, 1977), there has been, in general, a relative neglect of the problems and issues unique to mental health services in rural areas. Several recent reviews (Berry & Davis, 1978, Jeffrey & Reeve, 1978; Jones, Wagenfeld, & Robin, 1976) have addressed generalized concerns in rural community mental health. However, a comprehensive summary of the problems faced by mental health personnel in the establishment and delivery of mental health services in rural areas is lacking. The purpose of this review is to provide a summary of the problems faced by rural mental health professionals that have been reported in the literature. This review also includes problematical issues in rural mental health that have been personally troublesome in my own experiences in the rural setting. It should be noted that some of the problems herein discussed are not exclusively within

the domain of rural community mental health, and are shared, in certain instances, by some non-rural mental health centers.

Models of Community Mental Health

The urban-based and designed model of community mental health and mental health service delivery has been uniformly promulgated since the enactment of the Community Mental Health Act in 1963 (PL 88-164). Berry and Davis (1978) state that social factors unique to rural areas are not adequately taken into account in the process of developing mental health services. They state that "clinics located in rural areas have problems that differ from those of urban centers and that those problems require a reexamination of what has previously been the fairly uniform application of community mental health ideology to all areas of our society" (p.673). Numerous authors (Daniels, 1967; Jeffrey & Reeve, 1978; Jones, Robin, & Wagenfeld, 1974; Jones, Wagenfeld, & Robin, 1976; Kinzie, Shore, & Pattison, 1972) have found that the provision of mental health services to rural population is quite different than an urban population. The traditional urban model makes exclusive use of formal systems of service delivery and neglects the informal systems of service delivery often utilized in rural areas (Hammaker, 1978).

The National Institute of Mental Health has noted significantly different trends in expenditure patterns, employment and staffing patterns, and in service utilization patterns in rural vs. urban areas (HEW, 1974). It appears that the urban model of community mental health is inappropiate for many, if not all, rural

areas. Although some models of rural community mental health care have been proposed (e.g., Eisdorfer et al., 1967; Kantor, Kausch, & Smith, 1978; Kahn, McWilliams, Balch, Chang, & Ireland, 1976; Kinzie et al., 1972; Leunes, 1975; Libo & Griffith, 1966; Parrott & Sebastain, 1977; Shane & Seibert, 1977; Shupe, 1974; Thompson & Bell, 1969), very few comprehensive models of rural community mental health care are available (Naftulin et al., 1974). Bachrach (1977) has perhaps best summarized the issue of the applicability of the urban model to rural areas when she states, "The literature, however, contains relatively few references that are relevant to rural community mental health program requirements" (p.669). It would therefore seem that Berry and Davis (1978) are quite accurate in their description of rural community mental health centers as "idelogical misfits" (p. 674).

Some Characterictics of Rural Areas

A comprehensive review of all rural area characteristics is beyond the scope of this article. However, for purposes of familiarization, summaries of the pertinent areas of demographic data, rural mental health characteristics, and rural citizens' values are presented.

Demographic Data

Rural communites are typically defined on the basis of being located outside of a Standard Metropolitan Statistical Area (as defined by the Census Bureau), and by having more

than half their populations living in communities of 2,500 or less (Clayton, 1977; Segal, 1973). Beyond indices of location and population, there are no routinely used operational definitions for the classification of communities as rural. Although rural areas account for over two-thirds of the country's communities (Bischoff, 1976), only 76 (13%) of funded community mental health centers and 56 (11%) of the operating community mental health centers are rural (HEW, 1973b). As of 1973, twenty-six states and Puerto Rico had one or more rural community mental health centers (HEW, 1973a). Jones et al. (1976) indicated that rural community mental health centers were more heavily dependent on federal and state funding due to their inability to generate sufficient monies through local funding and client fees. Bischoff (1976) reported that rural dwellers had lower educational attainment and lower incomes than their urban counterparts. Four of ten rural families fall below the national poverty level (HEW, 1974). In rural areas there are more clients in dependency age groups; more married and fewer single, separated or divorced; more female and less black clients; and fewer individuals who have received prior mental health care (HEW, 1974). A large percentage of various ethnic groups reside in rural area: Fifty-five percent of native-Americans, twenty-two percent of Blacks, and twelve percent of Spanish-speaking citizens live in non-urban areas (Bischoff, 1976).

Rural Mental Health Characteristics

Seventy-five percent of the nations' rural counties have been designated "wholly or in part medically underserved" by the U. S. Public Health Service (Clayton, 1977, p. 1673). Jones et al. (1976) termed the geographic maldistribution of health manpower and services a "health resource imbalance" (p . 176). High rates of mental and physical disorder are noted in rural areas, while a dire shortage of general health care personnel exists. Specifically, a shortage of mental health practitioners has been noted in rural areas (Angerman, 1976; Gertz, Meider, & Pluckhan, 1976; Hoxworth, 1978, Jones et al., 1976; Naftulin et al., 1974). Only 3% of the nation's psychiatrists are found in rural areas (Jones et al., 1976), which prompted Werner, Knarr, and Stack (1978) to conclude that "rural areas face severe problems related to the inadequate distribution of psychiatrists" (p. 25). Few studies document the prevalence of mental illness in rural areas, and even fewer studies have determined the rural locale's need for services (Berry & Davis, 1978). Most rural community mental health centers "have neither the time nor the resources to conduct such research. Over the years there has been little research into rural mental health services" (Clayton, 1977, p. 674). Rural mental health has been vested with little status professionally (Naftulin et al., 1974). Cleary, the need for further research into the characteristics of rural community mental health might well

be considered a high priority.

Values of Rural Citizens

Rural communities tend to differ in their values and needs, as compared to their urban counterparts (Lechowick, 1978). The prevailing ideology of rural citizens seems to be one of "we can solve our own problems" (Angerman, 1976, p.2). Rural people have been characterized as being resistant to innovation and change (Bachrach, 1977), which may pose great difficulties for the development and implementation of new mental health centers and services in rural areas. Many rural inhabitants view federally funded programs and health services as aiding malingerers (Libo & Griffith, 1966; Parrott & Sebastian, 1977), a perception which does not facilitate community sanction of the rural mental health center.

Bischoff (1976) noted a sense of belongingness and community cohesiveness in rural areas. Other values held in esteem by rural folk are self-determination and political conservatism (Parrott & Sebastian, 1977); self-sufficiency and personal responsibility (Bischoff, 1976), and (from personal experience) rugged individualism uniquely intertwined with community interdependence. A strong influence from and reliance on religion has also been noted. The importance of a cohesive nuclear family is still apparent in rural areas. Authoritarianism, a stronger respect for government, and sexism are reported to be widespread in rural settings (Berry &

Davis, 1978). Community conservatism (Hoxworth, 1978) and a skepticism of "outsiders" (Buxton, 1976) have also been noted.

Entry Issues into the Rural Human Service Delivery System

There are numerous issues to be dealth with during a community mental health center's entry into the existing human service delivery system of a rural area. These entry issues, which overlap to some extent, can be grouped into three categories: (1) Needs assessment; (2) Entry problems of the community mental health center; and (3) Entry problems of the mental health professional.

Needs Assessment

The accurate assessment of the mental health needs of a rural community (cf., Jeffry & Reeve, 1978) is an essential aspect of community mental health. (Bischoff 1976) has speculated that each rural community has a "personality" of its own and therefore requires the "development of a community profile" (p.2) prior to effective mental health interventions. Bischoff has colloquially referred to the assessment process as "sizing it up" (1976, p.3). Others have indicated the importance and even the necessity for an accurate mental health needs assessment in rural communities (Eisdorfer et al., 1967; Kahn et al., 1976; Kinzie et al., 1972).

Parrott & Sebastian (1977) state that:

> Rural citizens often hold the belief that the

> community is organized into a workable, interrelated pattern that fullfills the social needs and perserves the social well-being of the majority (Buxton, 1976). Attempts to identify problems threaten community pride and cause anxiety for local citizens (p. 6).

With these ideas in mind, it is not surprising to find mental health needs assessment surveys unanswered, or to find resistance among community leaders in discussing the mental health needs of their constitutents. An aggressive needs assessment may tend to alienate the mental health professional in rural areas; sensitivity and tact would seem desirable. For purposes of needs assessment, the comments of Eisdorfer et al. (1968) are relevant. They emphasize the importance of going out into the community with the attitude of "learn from the community" (p.219). The mental health professional may be met with resistance and skepticism (Shane & Seibert, 1977) in attempts to carry out the needs assessment, and may be tempted " to short cut the assessment stage, assuming that it will accrue through actual working experience with other agencies" (Jeffrey & Reeve, 1978, p. 56). It is probably unwise to take this short cut, as it very well may cause greater problems in the future (e.g., political criticism for inappropiate planning, community agency resistance, funding difficulties, etc.). Jeffrey and Reeve (1978) suggest a gradual approach to mental health needs assessment, one that is congruent with the general "nature of the rural system" (p. 57),

as to prove the usefulness of mental health services. Although there may be merits to this approach, caution is advised with this mode of operation due to its potential for threatening existing human service deliverers (Jeffrey & Reeve, 1978). Berry and Davis (1987) were in agreement with Mermelstein and Sundet (1973), who proposed that the rural mental health professionals' role was to direct available resources and abilities to the phenomena of the community, and not to impose the prevailing professional methodology or ideology on the community. Without an accurate and comprehensive assessment based on community imput and geared to community needs, the delivery of mental health services to the community might be a risky endeavor. After all, whose needs are we supposed to be assessing?

Entry Problems of the Community Mental Health Center

A rural community mental health center will typically cover a number of small towns and villages in its catchment area. The location choice may be a very important factor in the sucess or failure of a rural community mental health center, as often times there is competition among small towns for the location of public services. "A single clinic serving a number of such towns has difficulty establishing an identity as the resource for all of them. The location of the clinic in one town may automatically alienate community leaders in adjacent towns" (Berry & Davis, 1978, p.674).

Careful assessment and consultation with leaders are advised in determining the location of a rural community mental health center.

Community conservatism has been a frequently noted feature of rural areas (Hoxworth, 1978), as has skepticism and apprehension about new mental health services (Luenes, 1975). Resistance to mental health may stem from a number of reasons, including the perception that mental health professionals are invading one's domain (Bischoff, 1976); the fear of the unknown (Butteweg, 1974); the perceived threat of mental health as upsetting the local human service delivery system (Parrott & Sebastian, 1977; Shane & Seibert, 1977); the resentment of mental health personnel by people in the community who are reluctant to relenquish their therapist roles (Berry & Davis, 1978); and the fear that the mental health professional will not be appreciative of the existing caregivers (Thompson & Bell, 1969). The remarks of Eisdorfer et al. (1968) are especially cogent here, as they comment that consulting with existing human service personnel is a necessary strategy in "learn(ing) from the community....The citizens in a rural community often manifest an exquisite understanding of the dymanics of this social structure, a kind of knowledge that can enormously expand a consutlant's vision" (pp.219-220). Kahn et al. (1974) have emphasized the importance of developing good relationships with the existing human service delivers.

Jeffrey and Reeve (1978) have pointed to local practitioners as a source of community knowledge, and the importance of involving the medical community (Luenes, 1975) in initial contacts has also been emphasized. Kinzie et al. (1972) have suggested using established professionals as a viable entry point into the rural community human service delivery system. It seems that much resistance can be overcome by meeting existing professional personnel face to face and dealing with their perceptions and issues during the initial contacts. An individualized introductory meeting with the human service personnel of a rural area can often allay their fears, decrease their resistance, and may even provide important needs assessment data. Sensitivity to local values and norms (Berry & Davis, 1978), a respect for the mores of existing practitioners (Eisdorfer et al., 1968), and a sincere desire to understand and appreciate the complexity of the rural practitioners' circumstances may help to alleviate the problems of resistance.

Although the mental health practitioner may enter into new contacts with existing community professionals with the best of intentions, it is not unusual to encounter hostile oppositionalism or blatant negativism (Libo & Griffith, 1966). These problems may not necessarily be due to issues of resistance or conservatism, but may be the result of community "skeletons" in the closet (Jeffrey & Reeve, 1978, p. 57). The new mental health professional may be unaware of the history of inter- or intra-agency conflicts, as the professional

enters the system as a naive newcomer. It is advisable to collect as much data as possible about the histories of the community's human service delivery agencies before making conclusive assumptions. These histories can be obtained through local community leaders. The support of community leaders is an extemely important ingredient (Eisdorfer et al., 1968) in the success of a rural community mental health center. A knowledge of community politics (Berry & Davis, 1978) and community power structures (Morrison, 1979) is vital. Communication with key local officials, be it formal (Kinzie et al., 1972) or informal (Gertz et al., 1975) can often be a source of support to a fledgling rural mental health center. Libo and Griffith (1966) asserted that the level of community cooperation with the mental health center often depends on the attitudes and opinions of a few local, powerful, and influential citizens. The importance of establishing community knowledge, sanction, and support is a crucial variable in the establishment and maintenance of rural community mental health programs. The support and public encouragement of local officials can be the greatest possible impetus for the healthy growth and development of a rural community mental health center. Bischoff (1976) has described the "collective memory" of the rural citizenry (p.5) with respect to prior negative contacts with mental health professionals, and provides an (unfortunate) anecdotal incident. Ginsberg (1976) also comments on the effects of prior unfortunate experiences of social work personnel in rural areas.

Parrott and Sebastian (1977) present additional evidence which tends to corroborate the durability of some rural citizens' negative attitudes towards mental health due to prior unpleasant experiences. It is not uncommon for a mental health professional to inherit such a state of affairs in the rural locale, and to grapple with these memories for a long time before one can be divorced from the negative "collective memory". Leunes (1975) alludes to the answer of this problem by "selling the service to the community" (p.375). The proof is in the data, and it is incumbent upon the inheritor(s) of this problem to rectify it if the community is to accept and utilize the services of the mental health center.

Perhaps the underlying theme of all issues concerning the entry of the mental health center into the rural human service delivery system is the issue of trust. Berry and Davis (1978) have emphasized the need for trust between local community professionals and mental health workers. Eisdorfer et al. (1968) have also indicated the importance of developing a trusting relationship with community members. Jeffrey and Reeve (1978) have perhaps best summarized the issue of trust in rural community mental health: "A person can be seen as a useful professional only if he can be seen as a trustworthy individual; in a rural setting, personal trust superceedes issues of competence" (p.57). Thus, given the high probabilities for the occurence of resistance, skepticism, hostility, oppositionalism, and a host of other relatively unsavory and adverse conditions, it is

advisable to go into the community with a sense of respect, humility, flexibility, and sensitivity to their existing values and conditions. The development of trusting relationships with the existing human service practitioners appears to be a precursor to successful mental health service implementation in rural areas.

Entry Problems for the Mental Health Worker

The initial entry of the mental health worker into a rural setting may often result in various types of problems. Morrison (1979) comments that in rural areas, "...mental health workers may be seen as different, even odd" (p. 17). Bischoff (1976) states that, "Mental health in rural areas is not such a new thing; it's we professionals who are new. We are strangers in a strange land" (p. 1).

The first problem seems to stem from the transition that the urban born and/or trained mental health worker must make to the rural environment. Clayton (1977) and Bischoff (1976) have commented on the difficulties inherent in making the urban to rural adjustment. It is the urban background itself that tends to make the rural citizenry perceive the mental health worker an "outsider" (Berry & Davis, 1978; Buxton, 1976, Clayton, 1977). Being an outsider poses both professional and personal problems for the new mental health worker in a rural community.

The mental health worker who is new to the rural setting may be

met with fear, mistrust, hostility, or apathy (Berry & Davis, 1978). Any new face in a rural setting is usually a highly visible one which routinely generates community interest. However, there appears to be an even greater impact and interest when the new face is one of a professional in general, and a mental health worker in particular. Mental health professionals are initially evaluated by their community image rather than their professional ability. Rural citizens often judge mental health workers on the basis of their manner of dress, age, appearance, education, language, values, beliefs, living patterns, and attitudes (Bischoff, 1976; Buxton, 1976; Parrott & Sebastain, 1977). Adaptability, flexibility, and sensititivity to the prevailing values and ideologies of the rural community can assist the mental health worker in adjusting to the new environment. As Parrott and Sebastian (1977) have said, "It is not suggested that mental health interviewers need to adopt all of the values of the community, but they need to accept the citizens where they are....Personnel have to be trained not only for rural community working, but for rural community living" (p. 9). As a newcomer to the rural setting, one might initially expect to be on "community display". Berry and Davis, (1978) suggest a resolution to this issue by commenting, "Mental health workers discover that they must play the game the rural community's way, and that it takes a while, as outsiders, to gain the trust

of rural people" (p. 675). Being on community display may be an uncomfortable endeavor for some mental health workers, and many may find it to be quite undersirable. Leunes (1975) and Berry and Davis (1978) have emphasized the importance of careful staff selection for rural community mental health centers. Eisdorfer et al. (1978) have listed timing, patience, personality, and style as important attributes for mental health workers in rural areas, Bischoff (1976) suggest versatility, adaptability, flexibility, and a willingness for community involvement as desirable characteristics of rural mental health practitioners. "Staff of rural mental health centers are often expected to become integrated into small-town cultural patterns" (Bachrach, 1977, p. 671). It is not uncommon for a new rural mental health practitioner to be beseiged with invitations to join churches, civic groups, social organizations, and the like. Care must be exercised in the handling of these gestures so as not to alienate or offend any persons in the process. The rural practitioner is reminded that community members may judge not only the individual but also the mental health agency on the basis in which the invitation is handled. "The most important asset for mental health programs in rural communities lies in the personnel who choose to practice in these areas...." (Bachrach, 1977, p. 671). Tact, kindness and an indulgence in the social amenities can be of great value in one's professional and personal genesis in a rural area.

Problems and Issues

"The helping professional in rural areas must wear many hats" (Bischoff, 1976, p. 6). Due to the scarcity of mental health workers in rural areas, the need for practitioner-generalists (Berry & Davis, 1978; Clayton 1977) is apparent. Specialization is often a luxury in rural community mental health. At various times the rural worker may need to exhibit a diverse and wide array of skills. It is not unusual for the rural practitioner to be called upon to lend expertise in forensic, psychodiagnostic, preventive, therapeutic, and consultative matters during the routine course of a day. Because rural mental health centers are often not divided into specialized service components, the care-givers and citizens in the community often expect enormous flexibility and a varied assortment of skills from the mental health worker. In many cases, community expectations of the mental health worker can be quite unrealistic. Lechowick (1978) has commented on the problem of the wide range of talents expected of the para-professional mental health worker by the community.

Community expectations may pose a problem for the new mental health worker. It is not atypical for new mental health personnel to [redacted] the receiving end of the "dumping" (Jeffrey & Reeve, 1978, p. [redacted] procedure, whereby existing human service deliverers transfer the more difficult clients to the mental health clinic with the expectations of an immediate "cure". All too often the mental health worker and the mental health center are evaluated on their ability to successfully deal with these previously defiant clients.

Parrott and Sebastian (1977) found that rural communities "sometimes over-interpret the expertise of the mental health intervener and avoid involvement in problem resolution" (p.8). Kinzie et al. (1972) suggested that the mental health worker clarify procedures, roles, responsibilities, and attitudes at the onset of inter-agency collaboration, presumably as a preventive effort aimed at alleviating unrealistic community expectation of the mental health worker. Jeffrey and Reeve (1978) have expanded on this theme by suggesting that mental health workers maintain an initial stance of great flexibility, while later, after the collaborative inter-agency contact has solidified, undertake a shaping procedure designed to educate community caregivers as to the parameters of mental health services and as to what constitutes an appropriate or inappropriate referral. It appears that the problem of unrealistic community expectations may be prevented by an educational effort on the part of the mental health worker to gradually inform the community human service deliverers as to the capabilities and limitations of the mental health services. If the mental health worker allows the perpetuation of some community members' delusions of mental health omnipotence, probabilities are that the community will eventually realize the fallacy of this idea, with the resultant effects being quite detrimental to the mental health worker's (and possibly the mental health center's) credibility.

Barriers to Service Delivery in Rural Areas

There are common stresses in service delivery in rural settings (Wedel, 1969). The literature reveals numerous obstacles that hinder or prevent mental health service delivery in rural areas. These obstacles can be broadly classified as geographical, financial, educational, and psychosocial.

Geographical Barriers

The geographical size of a rural community mental health centers' (CMHC) catchment area is typically quite large (Clayton, 1977). The distance, remoteness, and geographical isolation between the populace and the CMHC has been frequently noted as a primary barrier to service delivery in rural areas (Bachrach, 1977; Gertz et al., 1975; Hoxworth, 1978; Jones, et al., 1976; Kraenzel & McDonald, 1971; Naftulin et al., 1974; Taylor, Clow, Miller, Vijil, & Williams, 1973). The vastness of some rural areas tends to limit the accessibility of services (DeRita, 1978). The time required to travel within the catchment area (Kahn et al., 1976) causes difficulties for both consumers and providers. The dispersal of the population over large stretches of land also hinders service delivery (Bachrach, 1977; Berry & Davis, 1978; Gertz et al., 1975). The problem of transportation availability is directly related to distance, remoteness, geographical isolation, and vastness of area. The lack of client transportation in general (DeRita,

1978; Lechowick, 1978; Shane & Seibert, 1977) and public transportation in particular (Gertz et al., 1975) are crucial service barriers. The expense involved in CMHC staff travel to clients also causes difficulty. Although many rural CMHCs employ vigorous outreach efforts in an attempt to overcome geographical barriers (Berry & Davis, 1978; Shane & Seibert, 1977), funding for such activities is often limited (Gertz et al., 1975). Additionally, the energy crisis and restrictive weather conditions have been noted as antagonists to outreach efforts (Gertz et al., 1975).

Financial Problems

The poverty of many rural communities (Bachrach, 1977) makes it difficult to establish a comprehensive network of human service systems. The lack of funding for supportive services and facilities is a frequently noted deficit in rural areas. Clayton (1977) has addressed the problems of service funding in rural areas. The lack of general support facilities (Gaskill, 1978; Gertz et al., 1975; Naftulin et al., 1974); the paucity of specialized services (Eisdorfer et al., 1968); and the lack of adequate community resources (Kahn et al., 1975; Hoxworth, 1978; Jeffrey & Reeve, 1978) are all severe barriers to service delivery in rural areas. The plight of the aftercare client in the rural setting has received particular attention from the perspective of community support systems (e. g., Berry & Davis, 1978; Hammaker, 1978). If the aftercare client is to

become an independent and financially self-supporting member of the community upon discharge from the hospital, how can we realistically expect this to occur if the rural community cannot provide the basic supports that were available to the client within the hospital? Although financial problems are and funding issues are certainly not unique to rural CMHCs alone, their effects probably have a greater impact in rural locales. Should an urban CMHC lose part of its financial base, other public or private community agencies, or even volunteer organizations, may be in a position to assist or even compensate for the loss. Such is rarely the case in rural areas, making the issues of financial support an extremely crucial one for the rural CMHC.

Educational Problems

"Rural persons with mental disorder seek no help 50% of the time" (Berry & Davis, 1978, p. 675). This may be attributable to the rural citizenry's lack of knowledge of existing mental health services (Lee, Gianturco, & Eisdorfer, 1974). Parrott and Sebastian (1977) and Lechowick (1978) have specifically pointed to the fact that rural dwellers lack information as to the availability of mental health services. This problem is further compounded by a lack of understanding as to what constitutes a problem for which mental health care is to be sought (Lee et al., 1974), and by an insufficient recognition by rural citizens of discrete mental health

problems (Naftulin et al., 1974). Rural cultures may define problems differently than the prevailing mental health standards (Summers, Seiler, & Hough, 1971), and in certain ethnic subcultures (Taylor et al., 1973) some illnesses that are traditionally classified as mental health concerns are not defined as such by its consitiuents. The need for public education via newspaper articles, speeches to local organizations, the training of volunteers and indigenous paraprofessionals, brochures, listing in telephone directories, workshops, public displays, open houses, and other means are crucial and, if successful, may obivate some of the educational problems that prevent rural dwellers from utilizing CMHC services.

Psychosocial Factors

A general hesitancy to go to the CMHC has been noted in rural areas (Angerman, 1976; Parrott & Sebastian, 1977). The hesitancy of rural people to utilize CMHC services may be due to a variety of psychosocial factors. "Many people in the... area saw the center as a place to go if you were 'crazy', or for those who were too weak to take care of their own problems" (Shane & Seibert, 1977, p. 4). This quote highlights both the rural dwellers' esteemed values of personal responsibility and self-sufficiency, as well as referring to the fear of being identified and labeled as mentally ill. The stigma of being a mental patient in a rural area has been noted by

DeRita (1978) and Gertz et al. (1975). The stigma issue is a difficult one,both for the mental health worker and the rural client. Whereas the urban client has the luxury of anonymity and a greater opportunity for melting into the crowd, the rural mental health consumer often faces the problem of local visibility with a resultant higher probability for being identified as a "mental patient". Berry & Davis (1978) pay special attention to the problems of visibilty for the rural client. The issue of visibility is directly related, unfortunately, to one of the rural community's favorite pastimes, the art of gossip. While virtually no one can escape being the subject of gossip at one time or another in the rural community, the mental health client becomes a particularly vulnerable subject for gossip once identified as a mental health consumer. Given the rural community's proclivity towards gossip and the often high visibilty of the rural mental health consumer, it becomes understandable, from a psychosocial perspective, the reluctance and hesitancy of the rural citizen to utilize available CMHC resources.

Even if the rural client can overcome the issue of visibility and the potential risk of being the subject of community gossip, there are additional psychosocial factors peculiar to the rural setting that may cause difficulties in the provision of mental health services. Biscoff (1976) and Berry and Davis (1978) have shown that rural clients tend

to prefer individual mental health services, and are relatively reluctant to engage in group therapy. The Department of Health, Education and Welfare (1974) provided data to support this contention by reporting that at federally funded rural centers, individual sessions outnumber group and family sessions by a ratio of 6 to 1, while the ratio in part-rural centers is 5 to 1, and at non-rural centers, 4 to 1. Berry and Davis (1978), in referring to authoritarianism as a "hindrance to rural mental health service" (p. 676), cite Sawer's (1973) study of rural families, in which it was demonstrated that farming husbands tend to assume the major role in decision making, thus relegating the wives to a lesser role in family matters. Consequently, as Berry and Davis point out:

> Such nonegalitarian interaction affects the prospects for effective individual and family therapy. Fathers and husbands may forbid their children or wives to visit the mental health center, fearing that practitioners will undermine their authority; often these men will not personally participate in any form of therapy. (p. 676).

Although rural husbands and fathers may perceive the mental health worker as a threat to their authority, an equally plausible explanation for this reluctance to participate in therapy has been offered by Parrott and Sebastian (1977), who found among rural males "the notion that expression of feelings

and going for counseling was not "manly"." (p.7).

Additional psychosocial factors enter into play when one considers the delivery of mental health services to specific minority groups. For example, Taylor et al. (1973) have documented the difficulty in delivering mental health services to the Navajo population. Specifically, Taylor et al. found that Navajos do not trust white people; that traditional therapy is often unacceptable to the Navajos; and that language and cultural differences often interfere with service delivery.

The mental health worker in the rural setting is advised to be cognizant of these psychosocial factors, and is urged to use flexibility and sensitivity in trying to overcome these problems in the delivery of mental health services to their consumers.

Issues of Confidentiality

Morrison (1979) states that "Mental health agencies can be much more effective when there is full realization that a major concern of rural people when they seek help is confidentiality." (p. 18). Confidentiality issues in rural mental health may be divided into four major areas: (1) consumer concerns; (2) inter-agency concerns; (3)intra-agency concerns; and (4) the individual mental health workers' concerns.

Problems and Issues

General consumer concerns related to confidentiality in rural mental health were alluded to in the previous section on psychosocial factors (i.e., visibility, gossip, familial issues, fear of being labeled mentally ill). A more in-depth review of consumer confidentiality concerns in rural areas can be found elsewhere (e.g., Berry & Davis, 1978; Jeffrey & Reeve, 1978).

Inter-agency confidentiality issues pose a special problem for the rural mental health worker. In the initial stages of the establishment of the CMHC, most of the referrals are often received from existing community human service practitioners. These practitioners and/or their agencies routinely expect feedback on the status of their referred clients. The lack of compliance on the part of the mental health worker may cause severe inter-agency conflict. Jeffrey & Reeve (1978) comment:

> Although the right of confidentiality is becoming more accepted by rural professionals, informal channels of communication remain strong. There can be the assumption that the interagency sharing of information is not the same as divulging this information to the general public.... Holding very strictly to the rule of confidentiality can be interpreted as questioning

> the integrity of the other workers. At other times, refusal to share readily information on common clients is seen as indicative of the snobbery of mental health professionals, their "ivory tower" view of problems, or their preference for psychoanalytic theory over reality. (p. 58).

Morrison (1979) adds:

> Confidentiality in rural places is difficult enough and the demands by many agencies for information makes it more so....Conflicts over confidentiality ultimately lead to problems of power....Conflict with powerful agencies over issues such as confidentiality can result in reprisals at several levels, i.e., no referrals, bad mouthing in the community, resistance to funding and isolation. (pp. 17-18)

Although no clear-cut answer to this dilemma can be offered, rural mental health workers are advised to be aware of this potential problem, and to attempt its prevention whenever possible by informing the referral source at the time of the referral of the policies of the CMHC dealing with the release of confidential information.

Intra-agency issues of confidentiality can often be a source of conflict. Jeffrey & Reeve (1978) have provided a summarization of several key "in-house" issues pertaining

to confidentiality, e.g., the advantages and disadvantages of having local persons on staff, the use of volunteers, and the use of indigenous paraprofessionals. Another area of concern is the use of local college students, who may be fulfilling practicum requirements at the CMHC. There may be difficulties inherent in the student's attempt to provide the professor and/or class members with a comprehensive description of the client(s) with whom the student is working without risking some assurance of the confientiality of the client's identity. This especially can occur in rural mental health where only a general description of an individual may in fact be sufficient to cue another as to the identity of the client.

An additional issue is the question of general staff accessibility to client files or to computerized data banks for the purposes of curiosity or research. Other important areas are the difficulties associated with the provision of mental health services to CMHC staff members and/or their families, as these special circumstances may lead to unique problems of confidentiality. No definitive answer is applicable to all issues or even to all CMHCs. It is suggested, however, that CMHC directors and/or staff establish at the onset a set of policies and procedures to deal with these issues so as to prevent the occurence of intra-agency hassles.

The individual mental health worker's private debates over client confidentiality issues can be the source of excruciating

ethical dilemmas. The confidentiality literature, while providing generalized guidelines for ethical standards (e.g., A.P.A., 1977) reveals little to no specialized principles for the unique rural concerns. Morrison (1979) specifically criticizes his graduate training program for not addressing the issues of confidentiality. Mazer (1976) deals indirectly with the issues of confidentiality in a rural setting. Jeffrey and Reeve (1978) comment briefly on the confidentiality dilemmas associated with providing mental health services to prestigious community menbers, to staff members of other agencies and/or their families, and to local professionals. A relatively complex area of confidentiality with which the rural mental health professional must grapple is in the matter of forensic cases, where the balance between the rights of client privacy and the needs of the court are often diametrically opposed. The rural practitioner is then caught between the proverbial rock and hard place, as the laws of many states do not afford the non-psychiatric mental health professional with the confidentiality rights of the traditional "Doctor-Patient" relationship. Morrison perceives the issues and problems of confidentiality at a "cognitive and an ethical level"(1979, p. 19), and suggests Kohlberg's work on moral development (1971a) as a conceptual framework for understanding and clarifying one's position on these complex matters. However one chooses to

defines the issue of confidentiality, whether in a social, political, legal, moral, or ethical perspective, and regardless of the type of setting in which the mental health professional is employed, decisions concerning issues of confidentiality will be rooted in the individual practitioner's values. Those values will cut across and affect all perspectives.

Professional and Personal Issues of the Rural Mental Health Worker

As contrasted with their urban counterparts, rural community mental health professionals may encounter relatively unique professional and personal problems. Reflective of the dearth of studies on rural community mental health, the literature reveals no specific research dealing exclusively with the personal and professional problems frequently encountered by the rural mental health worker. Several recent studies (e.g., Berry & Davis, 1978; Bischoff, 1976; Clayton, 1977; Jeffrey & Reeve, 1978) have paid some attention to this specific issue within the larger context of rural community mental health concerns.

Libo and Griffith (1966), in commenting on their early efforts to provide mental health services to a rural area utilizing an "extension agent" (p. 164) approach, conclude that, "Success of the program....would depend almost solely

on the individual consultant's breadth of professional skill and upon his energy, imagination, tact, and flexibility" (p.166). The success or failure of a rural CMHC is often determined by the manner in which the few individual staff members can respond to and cope with the needs of the community, as well as various professional and personal problems unique to the rural practitioner.

Bischoff (1976) comments:

> Generally speaking, residents of rural areas must deal with a mental health monopoly, i.e., the public mental health center. Thus, a rural mental health system and its staff have a greater responsibility to be available to all the residents of the rural catchment area, because if that center does not provide service there are no other alternatives. (p. 12).

The resulting state of affairs is that the rural CMHC is often "the only show in town" (Champion, Note 3) which creates enormous demands and responsibilities for the rural practitioner (Berry & Davis, 1978) in meeting the needs of the community. Rural mental health workers must be especially responsive to immediate community service requests, for any delay in attention (or inattention) to such consumer needs may result in extremely unfavorable consequences for

the reputation and credibilty of both the mental health worker and the CMHC.

Other characteristics of the rural environment itself may cause further problems for rural workers. Jeffrey and Reeve (1978) have succinctly illustrated these pressures on staff:

> The staff members must be aware of and sensitive to "front line" pressures. Due to the small size of the organization, no bureaucracy exists. Clear-cut lines of authority and responsibilty among staff are absent. Thus each staff member must constantly weigh and balance the factors of clinical judgment, ethical responsibilty, and political reality.... Staffing decisions also require a careful balancing of priorities. When advertising for positions, some applicants undoubtedly will come from influential families. These applicants may not be appropriate because of skill deficiencies, personality characteristics, or other reasons. However, refusing them the position may bring about political pressure. (pp. 59-60).

The bureaucratic murkiness of many rural CMHCs, as well as the delicate issue of handling employment applications from

powerful and influential community members or their relatives can be sources of great stress for the rural professional.

Jeffrey and Reeve (1978) address another pressure-laden issue related to the rural practitioner's labeling of particular individuals with mental health problems:

> At times the center will be asked to provide services either to families of prominent people or to families of staff members of other agencies. Since it is important to maintain good relationships with these people, there is considerable pressure to label the problem in the manner most comfortable to the prestigious person. When this conflicts with good clinical judgment, the mental health worker is caught between his ethical responsibilities and the practical consequences of a confrontation. (p.60).

Although the issues of labeling mental health problems are not unique to rural areas, the practical ramifications of such particular labeling behavior in the rural setting may cause ethical, social, and political pressures on the rural practitioner, and even threaten the survival of the CMHC.

Jeffrey and Reeve (1978) present an additional ethical

dilemma that may create excessive stress for the rural mental health worker. The authors state that:

> Ocasionally evidence will surface that a local professional has been negligent or openly unethical in his performance of duty. Under other circumstances the obvious action would be to make a report of the incident, either to a professional board or to the agency involved. In a rural setting, however, the results of such actions may be mixed. Being a newcomer, there is always the risk that a premature challenge to the system will result in little except animosity and suspicion towards the center....Thus challenges on ethical grounds may endanger the future of the center with little hope of substantially improving the situation. At the same time it is hard for the responsible professional to watch scarce resources being wasted or misused. (pp. 60-61)

These ethically-based dilemmas can cause both professional and personal anguish and stress for the rural mental health worker.

Another concern is the predicament of the rural practitioner who encounters center clients in public (e.g., during the course of community events, socials, meetings, religious activities, routine shopping, etc.). Due to the lesser

amount of available public events and thoroughfares in a rural setting, chances are greater for the mental health worker to encounter center clients. This occurence may be awkward for both individuals, due perhaps to the confusion of roles described by Mazer (1976). Bachrach (1977), Bischoff (1976), and Gertz et al. (1975) have also addressed this dilemma. Principle 3 (Moral and Legal Standards) of the American Psychological Association's Casebook on Ethical Standards of Psychologists (1977) states, in part:

> Regarding their own behavior, psychologists should be aware of the prevailing community standards and of the possible impact upon the quality of professional services provided by their conformity to or deviation from these standards. Psychologists are also aware of the possible impact of their public behavior upon the ability of colleagues to perform their professional duties. (p. 2).

The specific issues of "prevailing community standards" and "the possible impact of their public behavior upon the ability of colleagues to perform their professional duties" are extremely relevant to rural practitioners. A rural mental health worker's simple public greeting to a Center client may be misperceived by the client as a blatant violation of confientiality. In rural areas it is not unusual

for some community members who publicly observe mental health workers conversing with particular citizens to assume that the citizen is in fact a CMHC client. Should such an assumption be made, it is possible that some rural dwellers might then be hesitant to seek mental health services due to their fears of being unintentionally identified in public by the mental health worker as a Center client. On the other hand, in many rural communities the social norm is one of greetings with virtually all acquaintances that one may meet in the public domain. Should a mental health worker encounter a Center client publicly and not extend the socially appropriate greeting, then it is very possible, and even probable, that some clients might view the mental health workers' behavior as that of snobbery or social exclusivity. Bischoff (1976) suggests a general rule of thumb for the mental health worker confronted with this dilemma: "When meeting up with a client around town most clinicians have resorted to waiting for acknowledgment from the client before offering a greeting" (p. 10). In some cases, this problem might be prevented by tactfully discussing the issue with the client within the confines of the consultation office.

Berry and Davis (1978) explore other areas:

> According to Buxton (1973), a....worker in a rural mental health setting may be set apart by age, dress, education, and value system from others in the community. There is an effective

> word-of-mouth network rural citizenry that reports all the activities of the mental health worker (O'Neill, 1972). Rural people are well-informed on matters concerning the worker's life, such as marital status, family stability, drinking habits, where clothes are purchased and their cost, kind of car driven, recreational habits, religious participation, and residence. Rural mental health professionals must be concerned about their image in the community because local people will judge them on the basis of the personal factors noted above, and this judgement will color their response to the professionals' services. (p. 677).

These comments are consistent with Bischoff's (1976) contention that the high level of community recognition given to the mental health worker often leads to a lack of personal space, which may be problematical for the rural worker. Bachrach (1977) and Parrott and Sebastian (1977) have also commented on the lack of anonymity for rural mental health workers.

Other problems that often beset the rural worker have been noted, and include, but are not limited to: professional isolation (Berry & Davis, 1978; Clayton, 1977; Jeffrey & Reeve, 1978); limited personal and professional rewards (Mayer, 1972); lack of continuing education opportunities

(Clayton, 1977; Jeffrey & Reeve, 1978); loneliness and little opportunity for professional kinship (Bischoff, 1976); staff fatigue and frustration (Shane & Seibertm 1977; Taylor et al., 1973); staff burn-out (Maslach, 1976); and the lack of travel money (Bischoff, 1976). These factors, alone or in combination, may be contrubutors to the often noted short-lived stay (Taylor et al., 1973) and rapid turn-over (Clayton, 1977) of mental health workers in rural areas. The perception of the rural setting as a purley idyllic environment is often quickly shattered for some rural professionals, and may contribute to burn-out and rapid turn-over. Bischoff (1976) summarizes some of these problems in saying that, "This constant endurance of public display, lack of anonymity and search for privacy together comprise part of the challenge to survive what has been termed the 'rural rat race'." (p. 8).

Special Topics in Rural Mental Health

Four areas of importance to rural mental health are deserving of special attention in this review. These areas include program evaluation, university activities, national organizational efforts, and the flux of rural America.

Program Evaluation

Problems with program evaluation issues are hardly the

exclusive concern of rural community mental health centers. Urban centers also tend to have difficulties with this important, frequently problematical, and often neglected area. However, the program evaluation literature deals almost entirely with the programs and operations on non-rural centers; few program evaluation reports of specifically rural activities have been noted. Those reported in the literature are reviewed below.

In discussing program evaluation, Gilligan and Wilderman (1977) comment:

> It is well recognized by the major contributors in the field of mental health evaluation that there is no single type of evaluation that meets all the needs of a mental health center (Davis, 1973; Guttentag, 1975; Rocheleau, 1975; Suchman, 1967)...Furthermore, the field of mental health evaluation is plagued with confounding variables that quickly discourage most workers from undertaking the journey, while at the same time the community is making consistent demands for accountability. (p. 31).

Given the previously described rural community characteristics of financial problems, political conservatism, and community skepticism of publicly supported health programs,

it is extremely important for the rural CMHC to provide the community in general, and its funding sources in particular, with evaluative data based on its operations and performances. In some rural areas it is not uncommon to find some politicians who attempt to alleviate their constituents' fears of rising taxes by promising to streamline or slash new programs, especially those programs which have yet to establish the validity and usefulness of its services. Mental health is often one of the newer human services in many rural areas, and can very well be a prime target of close scrutiny by local politicians at budget hearing time. Quantitative and qualitative evaluation data can possibly serve as one of the survival mechanisms for a new rural CMHC when funding and support issues are immediate and crucial.

McDowell (1977) states that:

> The need for viable program evaluation tools for mental health services is obvious to rural administrators. While larger community mental health centers are developing separate departments or divisions for program evaluation, smaller mental health clinics face some practical difficulties including limited resources and limited technical skills. (p. 6).

Clayton (1977) has also indicated that rural CMHCs lacked the time or the resources for research. Cardamone (Note 1) comments that the lack of sufficient staff, time, and money prevent rural CMHCs from actively pursuing research and evaluation activities.

Few reports of rural CMHC program evaluation studies are currently available in the literature. Heinemann and Yudin (1974) and McDowell (1977) have reported evaluative studies utilizing client satisfaction questionnaires. Laposky (1978) reports a summary of an evaluative unit-cost system for the benefit of rural CMHCs. Thompson and Bell (1969) reported perhaps the first evaluative study of a small rural CMHC. Gilligan and Wilderman (1977) have utilized a client satisfaction questionnaire along with an Adjective Generation Technique (Allen, 1971; Potkay & Allen, 1973) in their evaluative study, which cost less than $125 and required no more than eighteen hours of staff time. McDowell (1977) indicates that the cost of the consumer satisfaction questionnaire is under thirty cents per unit; that it provides valuable feedback from clients that allows staff to modify aspects of the clinic's operation and procedure; and that "the questionnaire has provided substantive, positive reinforcement to clinic staff for their performance" (p. 6). McDowell (Note 2) further reported that reducing the number of items on the question-

naire by 50% (i.e., from 20 to 10) has increased the response rate from 30% (1977) to 55% (1978).

It is clear that most program evaluation activities have been neglected in rural CMHCs. The frequently noted insufficiencies of staff, time, money, technical expertise, and viable rural evaluation tools, coupled with the often times more immediate and pressing demands (e.g. direct services) have resulted in the relegation of program evaluation activities to the role of "stepchild" in rural community mental health endeavors.

University Activities

A major frontrunner among universities in the area of rural community mental health has been the University of Wisconsin--Extension (Continuing Education in Mental Health, Health Sciences Unit, Madison). Under the initial leadership of Dr. Victor I. Howery, the Association for Rural Mental Health (ARMH) was established. ARMH has for years sponsored the Summer Study Program on Rural Mental Health Services, as well as the recently added Rural Mental Health Administrator's Program, both of which are held annually in Madison. Additionally, ARMH publishes the Rural Community Mental Health Newsletter, a periodical devoted exclusively to rural mental health concerns.

Another leader in the area is the Division of Community Psychiatry at the University of North Carolina Medical School. For quite some time they have been an advocate of and participant in rural mental health studies, activities, consulting, and training workshops. Duke University is also a leader.

Meyer and Gerrard (in press), in their review of graduate training opportunities in community psychology and community mental health, have noted a tremendous increase in the availability of such programs. However, the number of such programs geared specifically towards rural community psychology or rural community mental health remains quite small. The University of Wyoming's clinical psychology training program brochure (Note 4) has described itself as a graduate program for the education and training of rural community mental health practitioners. Recently, the University of Nebraska-Lincoln has announced the development of a specialty for clinical psychology doctoral students in rural mental health service delivery (University of Nebraska-Lincoln Specialty Training, 1979). Southern Illinois University at Carbondale specifically lists available rural mental health training experiences in its practicum listing of the doctoral program in clinical psychology (Note 5). The Community Psychology program at the University of Michigan displayed its interest in

making contact with potential doctoral students, and seemed to indicate the availablilty of rural mental health study and experience (Opportunity for Advanced Study, 1978). A brief review of Graduate Study in Psychology for 1978-1979 (American Psychological Association, 1978) reveals no other major university that has devoted specifically a major aspect of its doctoral training (in either clinical or community psychology) to rural community psychology or rural mental health. Clearly, the need for such rural-oriented training programs exists.

Kahn et al. (1976) and Miller and Aponte (1972) have described collaborative efforts between universities and rural communities to provide mental health services to underserved rural areas. Naftulin et al. (1974) engaged in an university-sponsored mental health education program for primary interveners in the rural community, and reported successful results. The College of Human Development of Pennsylvania State University is presently collaborating with a local multi-county mental health-mental retardation program in order to enhance the mental health service delivery system in a rural area ("Natural Helper Project in Pennsylvania", 1978). Hopefully, manymore such collaborative endeavors are operational. Many rural areas may be desperately in need of university assistance to help establish, or to

provide additional support, for community-based mental health services. Universities can often be of enormous value to rural CMHCs with direct service assistance, program evaluation skills, in-service training, consultation strategies, management information systems, educational techniques, research strategies and assistance, fiscal procedures, and a host of other truly interdisciplinary skills. In turn, the rural CMHCs may be a viable source of practicum and field placement training experiences for university graduate students (e.g., Kahn et al., 1976).

National Organizational Efforts

Among professional organizations, the Association for Rural Mental Health is probably the only group whose sole purpose is to deal as comprehensively as possible with the multi-faceted concerns of rural mental health. Division 27 (Community Psychology) of the American Psychological Association also considers rural community psychology/mental health issues and occasionally deals with these concerns in its Newsletter. Another professional organization that entertains issues of mental health services in the rural environment is the National Council of Community Mental Health Centers. Although other mental health organizations concerned specifically with

the issues of rural mental health may exist, probabilities are that their visibility is low, or that they are regional in scope.

Only within the last decade and a half has there been the development of specific federal governmental agencies and/or task forces to address the issues of rural mental health needs. Some of the major ones are: NIMH's Mental Health Services Branch, which in 1967 included a coordinator for Rural Mental Health Services, Research, and Training; two programs sponsored by the Bureau of Community Health Services (i.e., Rural Health Initiative Program and the Health Underserved Rural Areas program, 1975); The Task Panel on Rural Mental Health of the President's Commission on Mental Health (1977); the 1978 Rural Alcohol and Drug Agencies (RADA) section of The Alcohol and Drug Abuse Problems Association Board of Directors; The 1978 Rural Drug Task Force; and the 1978 Rural Health Council. Other such agencies or task forces dealing with the specific problems of rural mental health are likely to exist. The above listing is not intended to be comprehensive, but merely illustrative of current federal attempts to reverse the historical neglect of rural mental health needs.

The Flux of Rural America

"The development of a flexible, responsive program is

particularly important for the rural mental health intervener because of the fact that rural America is no longer static and unchanging" (Parrott & Sebastian, 1977, p. 15). Rural communities are often far removed from many stereotypical notions of it. Some rural communities are vigorously pursuing modernization (though not necessarily urbanization) and are taking progressive steps towards improving the quality of life in their environments. Bachrach (1977) comments:

> In many rural portions of the nation, the entire demographic scene has been, and continues to be, in flux. Plagued first by outmigration and the stresses imposed by selective depopulation, much of rural America has recently had to cope with a new set of stresses: the reversal of a long-established trend towards urbanization. (p. 671)

It is incumbent upon the rural mental health practitioner to be aware of and constantly responsive to the individual community's rate of change, and to adjust and revamp mental health services in accordance with the needs of the community.

Conclusion

This review has demonstrated a multitude of problems

which may exist for the mental health professional who chooses to reside and practice in the rural setting. Although the number of problems readily visible in rural mental health may appear to be inordinate, probabilities are that the difficulties found in rural locales are quantitatively no different than those found in non-rural areas. The differences may be purely qualitative. To be sure, rural community mental health and rural living are endeavors sprinkled with various challenges, and may, at some junctures, tax the abilities of the best of mental health professionals.

Jeffrey and Reeve (1978), in their conclusion, provide us with a valuable insight:

> To suceed, ... it is necessary to under-
> that as a part of the professional community
> the worker must also function within the
> social, political, and cultural framework.
> It is only possible to make this adaptation
> if he has an accurate assessment that has
> been developed through a slow and careful
> process---one in keeping with the nature
> of the system in which he operates. (p. 62).

Jones et al. (1976) stated that

> Although we may rue the paucity of rural

> mental health centers and their fiscal constraints, we must note the extraordinary nature of the centers that have been established. Our data support....the observations of Vernon Wilson, who asserted that rural community mental health centers were remarkably effective in penetrating isolated rural areas. (p. 181)

Wilson (1971) concluded that the rural community mental health center approach has "served as a model for community development of broader health care delivery systems".

This article has focused on issues and problems in rural community mental health. It does not document the many successful mental health centers and programs in rural areas. Such a task is beyond ths scope of this review. Although this article does not mention the tremendous sources of personal and professional growth which can be derived from working and living in the rural environment, to conclude that these satisfactions do not readily exist would be quite premature. These satisfactions and gratifications are experienced not only by the rural mental health practitioner, but also by the community members who share and contribute to the process that makes rural living the pleasure that it is.

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